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Increasing Access to Vision Rehabilitation Services for Seniors

through Collaboration with Occupational Therapists

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Increasing Access to Vision Rehabilitation Services for Seniors through Collaboration with Occupational Therapists

Due to the aging population, adults with vision loss are expected to double over the next 30 years (CDC, 2009). Fresh ideas for increasing efficiencies are needed to address the growing need based on the limited professionals currently stretched to capacity. Although collaboration with Occupational Therapy services is not a default for vision rehabilitation, it may increase the quality of services, number of individuals served, and help distribute the financial burden, while more efficiently employing the expertise of limited vision rehabilitation professionals.

Traditionally, vision rehabilitation professionals include vision rehabilitation therapists-- also known as rehabilitation teachers (VRT), orientation and mobility specialists (O&M), and low vision therapists (LVT). These professionals help individuals with vision loss attain independence and improve quality of life through instruction in adaptive techniques for home and personal management, orientation and mobility, communication skills, low vision strategies, use of technology, and recreation and leisure pursuits (Giesen, Cavanaugh, & Johnson, 1998).

Limited funding and certified professionals have constrained the ability of vision rehabilitation programs to serve substantial numbers of those who could benefit from these services (Mogk & Goodrich, 2004). One example is the Older Individuals who are Blind program, which is active in all states and territories and serves those 55 and older who do not have a goal of returning to work. The Older Individuals who are Blind program served less than 1.4% of those potentially eligible for services in 2013 (Farrow & Steverson, 2016). Lack of sufficient vision rehabilitation professionals is attributed to university preparation programs inability to graduate the number of qualified professionals needed (Geruschat, 2007) and Medicare not recognizing these professionals by reimbursement of their services (National

Academies of Sciences, Engineering, and Medicine, 2016). According to the ACVREP directory of certificates, there are currently 453 certified LVTs, 658 certified VRTs, and 2899 certified O&Ms (ACVREP directory of certificants, 2017).

Historically, licensed occupational therapists (OT) and certified occupational therapy assistants (OTA) did not provide low vision services. A change occurred when Medicare and Medicaid updated the definition of physical impairment to include vision loss in 1991 (Mogk & Goodrich, 2004), followed by the defining of national low vision rehabilitation coverage in 2002 (Berger, 2013). Since OT preparation did not include specialized training in blindness and low vision, professionals from the vision rehabilitation field were resistant to OTs providing services (Geruschat, 2007). With OTs recognizing the need for specialized training in low vision, the first OT preparation program launched in 2002 through distance education at the Department of Occupational Therapy at the University of Alabama at Birmingham (Warren & Barstow, 2007). In 2006, a specialty certification in low vision was created by the American Occupational Therapy Association (Berger, 2013).

Due to current limits faced by traditional vision rehabilitation services, the projected growth of those aging with vision loss, and the higher odds of these seniors having additional comorbidities (Steinman, 2016), program managers and administrators are beginning to find new ways to integrate a wider range of professionals (including OTs) into their service models. These examples serve to demonstrate how collaborations can benefit vision rehabilitation services, especially those for seniors.

One example is NewView Oklahoma, a non-profit agency who has provided vision rehabilitation services since 2006. In 2011, NewView decided to add OTs and OTAs to their model.

The groundbreaking NewView approach was built on several key considerations: no single profession can function in isolation, there is a lack of qualified vision rehabilitation personnel available, and monies generated through medical billing could help ease fundraising requirements.

Vision rehabilitation services have long recognized the importance of providing instruction to clients in all areas of life, but sometimes lack the necessary staff to address all areas. Instructing a client to travel safely to their mailbox, but not the adaptations for reading the mail they have received, or providing assistive technology training, without also the know-how for using public transportation to travel to a job, does not really address the entire picture. Therefore, it is a given that an agency strives to provide a wide array of professional disciplines to work in tandem to meet a client's goals.

While vision rehabilitation professionals cannot bill insurance for services, OTs can bill insurance. For non-profit agencies who have to fundraise 100% of their cost of services, tapping into the guaranteed stream of OT reimbursement is appealing.

Initial challenges faced by NewView included a lack of OTs who possessed specialized knowledge of low vision, lack of low vision clinicians, and limited knowledge by eye care professionals about the importance of vision rehabilitation services. NewView hired OTs and developed its own core training program. Topics covered during the training included: physiology of the eye, the pathology of common eye conditions, information about reading an eye report, low vision aids, diabetic education, lighting prescriptions, medication management,

and low vision strategies. Additionally, new hires were asked to wear simulators for portions of the training. Each new hire shadowed other professionals from the organization to learn about their duties and roles. Cross-training in areas like human guide were provided.

NewView also identified a need to establish low vision clinics and train optometrists to provide low vision evaluations. NewView invested in the training of its own optometrist and funded the opening of the state's first comprehensive low vision clinic.

Relationships were established within the community through educational opportunities for optometrists, ophthalmologists, and retina specialists. In seven years, NewView has built a base of over 550 referring physicians. The resulting 100 plus referrals each month represents the success of this endeavor.

The following is a picture of how services would look at NewView while at full staffing levels. Since referrals come from medical professionals, clients are referred to as patients in the NewView model. A patient is referred to the low vision clinic by their eye care physician. After a comprehensive evaluation including acuity measurement, field-testing, and device demonstration; the patient is referred to either an OT or LVT who provides follow up instruction with prescribed magnification aids and low vision techniques in the clinic. Soon after clinic instruction the VRT or OTA visits the patient in their home to see how implementation is proceeding. For instance, the patient may be attempting to use the magnifier to set the oven temperature and washing machine. Providing bump dots along with instruction help the patient complete these tasks more safely and efficiently. Additionally the patient may struggle with their new magnifier, as the easy chair does not provide a solid surface like the table in the clinic. The itinerant professional provides a lap desk or suggests alternate locations for more efficient use of the device. With timely follow up in the natural environment, rehabilitation professionals help

the client to transfer skills and techniques and encourage setting longer-term goals, like orientation and mobility or use of assistive technology.

Services at NewView do not usually happen simultaneously. Many patients are overwhelmed and find it necessary to accept one service at a time. The NewView model linking medical and rehabilitation services insures patients keep progressing from service to service.

Challenges to administering a seamless program include staff shortages, insurance regulations, and waiting lists. Employing sufficient numbers of LVTs, O&Ms, and VRTs has been difficult. Waiting lists are a direct result of limited staff. NewView is committed to providing high quality services by professionals who are certified to provide that service, such as a patient needing mobility services waiting for an O&M. The lack of sufficient VRT and LVT professionals are addressed by use of an OT or OTA, although NewView would prefer to provide more services using a VRT or LVT. With greater access to a VRT or LVT, insurance challenges could be mitigated. Since a VRT or LVT do not need a doctor's order, their services could be engaged to serve those waiting for insurance paperwork or to fill the need when insurance coverage is unavailable.

Services are provided with minimal expense to the patient in the NewView model. Besides being responsible for co-pays and deductibles, the only real cost to the patient is for low vision devices. Grants have been obtained to help cover costs for those who need assistance.

Minnesota State Services for the Blind

As part of the federal Older Individuals who are Blind program, the Minnesota State Services for the Blind (SSB), provides services to those 55 and older who do not have a goal to return to work. In addition to federal funding, SSB receives substantial state funding enabling the program to provide assistive aids/devices, orientation and mobility, adjustment to blindness

training, and assistive technology instruction from in-house instructors and vendors (at no cost to the client).

Faced with rising costs and a rapidly aging population, the program has struggled to maintain its level of service. Anticipating the need for structural changes for sustainability, Minnesota contracted with the Hubert Humphrey School of Public Affairs to study potential programmatic solutions to provide similar services for more seniors while managing rising costs.

The solution that showed the most promise was simple, straightforward, and clearly cost effective: provide training to those already working with seniors to initiate basic interventions with these individuals in the early stages of vision loss. For seniors whose needs were beyond these basic interventions, a referral would be made to SSB. The program, known as the Aging Eyes Initiative, launched in December 2015.

Through this initiative, MNSSB staff members reach out to allied health and other organizations that serve seniors. The outreach determines whether organizations are interested in becoming, and whether they have the capacity to become, partners. If they are interested and have qualified professional personnel, MNSSB provides four hours of training that teaches new partners recognition of vision loss, knowledge of the various simple low vision devices, data recording and the terms and conditions for becoming a partner.

At the successful completion of their training, health professionals, now partners, are provided with a low vision kit that contains items such as signature guides, adaptive kitchen and household items, large-button telephones, talking timepieces, low-power handheld magnifiers, bold-line paper, and other low-tech items. Through a simple one-page form, the partner records the services rendered and devices provided, and submits that form to MNSSB. Using the form, partners indicate individuals who have more advanced vision rehabilitation needs and who have

requested follow-up from MNSSB. MNSSB staff records that information, sends the partner items needed for resupply, and follows up with those seniors with greater vision loss.

Minnesota's Aging Eyes Initiative is fully funded for at least three years, with an additional two-year option. Funding comes from several different sources. One grant is from the Minnesota Department of Human Services Live Well at Home Initiative, which funds programs who have a mission of helping seniors maintain independence in their living environments. Other funding comes through a donor-advised, philanthropic fund of the St. Paul Foundation. Total funding for federal fiscal year 2017 is \$175000. These funds cover a program coordinator, training costs, travel costs, and the cost of low vision kits and contents.

The outcomes of the program have been promising. In all, the program has approximately 260 individual partners. About one-third of those partners are Occupational Therapists. Other partners include Parish Nurses, home health care providers, and other assorted allied health professionals. In federal fiscal year 2016 partners served 450 seniors, of which 150 were served directly, or more intensively, by Minnesota's SSB program.

Contact with an Aging Eyes partner has proven to be an excellent entry point to the SSB program. Barriers of resistance and denial that seniors frequently experience when considering vision rehabilitation are bypassed when the initial contact comes from another senior service provider.

The Aging Eyes Initiative has achieved several outcomes. First, it has obtained more referrals for individuals who need intensive vision rehabilitation services. Second, it has served more individuals who might not have been served otherwise, due to their vision loss not being as advanced. Third, it has empowered professionals who serve seniors, such as OTs, to perform basic low vision interventions; including knowing where to refer the more advanced cases of

vision loss. New human service organizations and health care entities are slated for training in 2017. Among those scheduled to become partners, approximately half are OTs. The initiative has freed Minnesota's SSB staff to concentrate their efforts on those seniors who require the most intensive services. Additionally, the initiative offers SSB a means to promote sensitivity and strategies about vision loss to professionals who work with seniors. Occupational therapists have been particularly open to this program for assisting individuals to find solutions and adjusting to vision loss.

Discussion

When adding low vision knowledge to the OTs' repertoire, they become a valuable member of the vision rehabilitation team. OTs seeking to provide low vision rehabilitation services should obtain specialized training from a university program for O&M, LVT, or VRT. Additionally OTs may consider programs like the low vision certificate program from UAB--or one of the alternative tracks--to certification from ACVREP or AOTA. We recommend that if agencies choose to do their own low vision training, a set curriculum be used and certification be encouraged.

Vision rehabilitation professionals, (LVT, O&M, and VRT), have niche roles that will not be usurped by OTs as long as vision rehabilitation professionals value certification and learn to demonstrate the importance of services using measurable outcomes. Challenges to the growth of vision rehabilitation fields continue to be the limited professional preparation programs, resistance of agencies to require certification, and inadequate funding limiting the salaries for these professionals.

The fact that OTs can obtain medical reimbursement and VRT, LVT, or O&M professionals cannot, causes great anxiety about job security for the latter professionals.

Agencies who aim to closely link traditional vision rehabilitation services with occupational therapy should strive to obtain the buy-in of the vision rehabilitation professionals through a culture of open communication, and when possible, inclusion of their suggestions. Despite resistance to these partnerships, vision rehabilitation professionals need not feel intimidated since the two models described above did not result in elimination of any vision rehabilitation positions. In fact, it could be argued that a greater demand for vision rehabilitation professionals has resulted.

Conclusion

There is room for substantial growth for vision rehabilitation services considering the small number of individuals currently served and the projected growth of this population. With university preparation programs not expanding and funding, including Medicare reimbursement, stymied, expansion of traditional programs and services is challenging. Although efforts exist to potentially change these factors, we must seek solutions that work under these current conditions.

The NewView and Minnesota SSB programs stand as successful examples of collaboration with OTs. Each professional who works with the older individual with vision loss brings expertise in specific interventions, varied perspectives on rehabilitation, and diverse funding which covers different components of services. When collaboration is employed, the quality of services for seniors is strengthened. Intentional collaboration between vision rehabilitation programs and OTs will help increase referrals to vision rehabilitation programs, give clients the most comprehensive service experience, and maximize the use of limited resources.

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